CHAPTER III: MIND-BODY MEDICINE

Questions & Answers

Q: Why group therapy rather than individual therapy?

A: I do a lot of individual therapy, too. In part, this started because my mentor who brought me to Stanford is Irvin Yalom, who wrote the bible on group therapy and is a superb leader. When I was an assistant professor, he called me up one day and said, "I'm leading this group of women with metastatic breast cancer, do you want to co-lead with me." I thought about that for a second and said, "Yes." I think both are good but actually, Jeanine Davis, in our lab, has just completed a pilot study with about 40 women, 1/2 of whom got individual and 1/2 of whom got group-randomized. The group results look better. They both improved, but the group more. I think there are special things that go on in group. Part of it has been called the helper therapy principle, that you feel better about yourself to the extent that you can use your experience to help others. That doesn't happen so much in individual therapy. But here you feel like an expert in life and dealing with the disease. I'll give you one example. A woman said, "You know I just got back from Kaiser and I learned a trick. I'm used to waiting 3 weeks for the results of my bone scan, but I discovered that you can walk up to the clerk at the front and demand to get your wet reading, the technician's reading of the scan. You say, 'I know it's not the final word, but I want to know now what it looks like.' And you can get it." So she's now learned something that helps other people. There's nothing good about getting cancer, but if you can use your experience with it to help someone else, then you feel that something genuinely good has come out of a bad situation. It's why, for example, when there was the shooting outside of Colorado at Columbine High School, the parents from the Paducah, Kentucky, high school, who had lost children there, called them up and said, "Here's what you're going to go through." Now why would they revisit their own sadness? They wanted something good to come out of a bad situation. I think the same situation is true in these groups. I've worked in these groups for 20 years— I try hard to structure the discussion. If you asked my patients what helps them the most, they'd say

"We help one another." It's the other women in the group. That makes me feel good. That means I'm doing my job to help them do it. So I think there's something about this ability to give, as well as receive, help that is powerful. Also, for people who are more reluctant to engage, they can get a lot just by watching what the others are doing. They also get the message that if they risk a little more, they'll get a little more. So I think there are things that go on in groups that are very powerful that supplement what you can do in individual therapy.

Q: What about men in groups?

A: We have run groups of men, both family members of patients and also men with prostate cancer and men with HIV infection, so we have a fair amount of experience with it. Now it is true that men are rather different, particularly in their inclination to express emotion. Somebody said that a man's notion of expressing emotion is the phrase, "I like beer." That's about as far as it goes. But we've actually observed that when men get a chance, they go for it. They do it differently, in a more structured way. In the breast cancer groups, the women will say, "Mary, you look unhappy. Has something gone wrong? How are you feeling?" The men will say, "It says here we're supposed to talk about feelings and you're not talking about your feelings, so tell me what you're feeling." It'll be more structured, however, I think there's a sort of higher threshold to get over. But men have fewer opportunities in life to do this than women do. Some of it comes down to common humanity and dealing with these existential issues, and I think, once you get over the initial reticence, men actually do this quite well and need it. There's a message in the fact that the support program for men, the sort of self-help support program for men with prostate cancer, is called Us TOO; they got so frustrated that the women with breast cancer were getting all the attention that that's what they named the group. So I think they're catching on to the idea that they need it. A husband in one of our family groups said, "This is a place where I come to feel better about feeling bad." So I think men need it, but it just takes a little more to get them hooked on it and doing it.

Q: Have you developed an idea about the optimal number of members in a group?

A: Yes. I think it's somewhere between 7 and 12. If you get 6 or fewer, it gets a little awkward. There's too much pressure on people to say something even if they don't feel like it. With more than 12, it just gets hard to handle; there's too much going on. So around 8 to 10 people is optimal.

Q: Can you be taught hypnosis by reading a book or do you have to go to a practitioner?

A: You can. I think it depends on what you're using it for. If your interest is kind of recreational and personal growth, there are good books and bad books. So I would go for a book by someone who is a licensed trained professional who also uses hypnosis. There's a Web site for the Society for Clinical and Experimental Hypnosis, or SCEH. It's the organization of professionals who use hypnosis and are dedicated to research, as well as clinical work. There's a lot of pop self-help stuff about hypnosis that, frankly, is pretty tacky. So I'd find a good book. But if you want to do it just to learn sort of a little more about yourself, sure. I think if you have a clinical problem—a travel phobia or pain or an anxiety problem—it's a good investment to go to a licensed and well-trained professional who uses hypnosis. I often see patients just once. I'll evaluate them, see how hypnotizable they are, and teach them a self-hypnosis exercise, go through it with them, and then they're on their own. So often you don't have to go back time and time again. You can just learn about it.

Q: How do you find a licensed professional?

A: Well, the SCEH Web site is one possibility because we have members around the country who we can make referrals to.

We have a Web site that you can visit that has some of this material there or refers you to publications where you can get more—www-med.Stanford.edu/school/psychiatry/PSTreatLab/. A little bit of this material is there, but references to where you can find the other information are also there.

Q: Are there alternatives to randomized trials?

A: This is a very interesting and important question, and I commented that it was more and more difficult to do true randomized controls and how people have looked at other ways of doing this kind of research. It reminds me of a comment Joan Baez made about nonviolence. She said nonviolence is a failure. The only bigger failure is violence. The same is true of randomized control trials. They're very hard to do. They distort things. You get a subgroup of people who are willing to accept randomization, which means it's not generalizable to everybody. On the other hand, we haven't yet come up with a better way to scientifically demonstrate whether or not a treatment works, although many people have tried. So, on the one hand, I admit to frustration with it, and on the other hand, I have to say I don't know anything better. There's a discussion in the research community about 2 kinds of scientific error. One is called type I error—that's a false positive. We've been very nervous about falsely claiming a treatment is effective when it isn't. Randomization is a good protection against that. If you can't show a difference between the 2 groups then the odds are they're not different. The other is type II error—that's a false negative, claiming that a treatment is not effective when it is. Now there are lots of people that go around in medicine and have for thousands of years, claiming treatments work when they didn't. The modern era of scientific medicine has come to us in part because we're willing to test our treatments and say when they don't work. At the same time, randomized trials can sometimes give you a false negative because you have to coerce people in the treatment, or to go into treatment, and dissuade people in the control arm from getting the treatment. They may go out and get it anyway. We know that some of our control patients are in groups. One of my control patients in a current study marched into my office one day and said, "I want a list of all your control patients so I can start a support group." I said, "I don't think so." In fact, to give you an idea of how the climate has changed, in the late 1970s, when we started our first study, the big problem was convincing the women in randomized treatment to go to it. They'd say "Look, I got radiotherapy, I've got chemotherapy, I feel like hell. You mean I'm supposed to go to the medical center once a week and sit and talk about it? You're

kidding. I don't want to do that." So we had to kind of coerce them into coming to group. Now the problem is that the women randomized to the nongroup condition are unhappy about it. So the climate has changed. It is very difficult to do these studies. You have to keep in mind that there are still factors that will distort what you know.

There are also other ways to try and do it. You can try and match people, but the problem is whether the matching was good enough. Is it an honest comparison? There are also ways of analyzing who tends to benefit from treatment more than others, and trying to tailor treatments to people who are most likely to benefit. For example, we found, and Dr. Goodwin found also, that the women who benefit the most emotionally are the ones who were the most distressed to begin with, which makes sense. There's relatively less group effect on those who were mildly anxious and depressed compared with those who were quite anxious and depressed. So we have ways of kind of refining the studies and picking people who are most likely to respond to intervention. So far, nobody has come up with something that really does what randomized trials do without the side effects of them.

Q: What are the durations of the groups?

A: When we started out for metastatic breast cancer, we figured on a year of therapy. That's substantial. Once a week for a year, that's pretty good. I think one of the reasons that some of the other trials don't turn out better than they do is that's all they do. Now that may seem a little bit strange, but if you think about it, you've got advancing breast cancer. You know that one day it's likely to kill you. You've watched other people in your group die of it. The women in many ways view the group as a kind of social insurance policy. They say, "I helped them through their deaths; I sure hope this group will be around for mine." We have 2 groups that have run 10 years. I have some women that have come almost every week for 10 years. In fact, at one 5-year point when I wasn't sure whether my grant would get renewed, I went up to the San Francisco group and said, "You know we may have to stop the group." They got angry at me and said, "Why didn't you tell the NIH that we'd need 10 years of group support?" I can just picture the look around the group, "Oh yeah, 10 years, right, of group therapy." But I'm here to tell you

that they come. Now they signed on for a year, and research study or not, if they weren't getting something from it, they wouldn't come. One of the women said, "This group is the least superficial thing I do in my life." So I think for people with illness that's likely to shorten their lives, there's no good time to stop, and the best thing to do is just keep it going and replace members as they die or leave, because some do. For women with more acute disease who have just recently been diagnosed with breast cancer, I think you can do a shorter 12- or 16-week model to kind of help them get through the transition of coming to terms with being a cancer patient. But you know what? Even when we've done that in randomized trials, we find that the women don't want to stop meeting, and some groups have hired their own therapist or meet once a month in somebody's living room. There's a kind of social glue that gets going. Once it gets started, people don't want to stop it. Group therapy is also very inexpensive. It's 8 people and a therapist or 2 therapists. So there's really very little downside in keeping it going. I was talking in the belly of the monster at Kaiser Permanente headquarters in Oakland, California, and they had some nurses who had been running groups, and they were reporting that the patients seemed to like it, but they had a problem. I asked, "What's the problem." They said, "Well, the patients have become dependent on it. They like it. And we have to wean them off their dependence." I said, "This is a real problem when patients actually like a medical treatment. That's terrible." Then I said, "I thought the term Permanente in your title meant permanent." They didn't like that very much. But patients like this. So I actually am thinking that longer is better in many of these circumstances.

Q: Do you deal with faith and spirituality in the groups?

A: I'd better say "yes" or I'll be struck by lightning, especially with the current administration. I'm interested in it, and I actually just spoke at an NIH conference on spirituality and health not too long ago. It's an interesting area. We tend to focus on the existential issues up to the moment of death, and what people feel happens to them after death is a matter of personal belief that I respect, but we tend not to go into. We tend to have people in the group who are wildly different in their faiths, ranging from a woman who was crying here as a fundamentalist Christian, who has had 3 episodes of brain

metastases and believes every time that it's God's will that it happened and he will rescue her, and she's done extremely well. We've had others who were agnostics or atheists. I remember having one group meeting where I really thought I was in trouble because she was talking about her faith, and one of the atheists said, "I don't believe for one second there's any intelligence in the universe that gives one damn about what happens to any of us." I thought, "Oh boy, here we go." You know what? The other woman smiled and said, "Well, God will find a way to save you, too," and that was the end of it. What I do avoid is arguments. I avoid proselytizing in the groups, and I think this whole issue of faith is a very complex and interesting one. I would say that I think one thing that we deal with in the group is the issue of meaning. Irvin Yalom, who has a wonderful book, *Existential Psychotherapy*, said that there are 4 ultimate concerns that we have: death; freedom; meaning; and isolation. For many people, their religious faith addresses some or all of those concerns. But for other people, they do it in other ways. So I think it's important to interweave people's sense of meaning and purpose in what we do in the group. But because we include people from many faiths and because I don't have any training as a pastor or a rabbi in any particular faith, I don't go there. So it's a matter of finding a way to be respectful of people's faiths but not letting it interfere with the kind of existential process that's going on in the group.

Q: Altered cortisol levels may accelerate the growth of tumors; can it initiate it?

A: It's a very important question. There are a couple of issues here. One is, by the time you discover a cancer in your body, it's been there for a while. Probably years by the time a tumor gets big enough. So what we view as a kind of bright-line distinction between incidence and progression really isn't biologically. But I would say, for example, that the studies, and there are about 8 good studies now, show that major depression elevates the risk of cancer incidence or progression. Major depression is often associated with abnormalities in cortisol, as I showed you with people tending to have high cortisol levels that don't shut off even when the cortisol comes back up; this would suggest that it might increase the vulnerability to getting cancer as well as the progression of cancer. There's a lot more we need to know about it, but I think it's entirely possible

that that's the case. There are also 2 recent papers in the *Journal of the National Cancer Institute* on women who work night shifts. These women are at higher risk for getting breast cancer. One thought is that there are aberrations of a hormone called melatonin, which is light sensitive—comes on at night and goes off during the day. I take it for jet lag when I travel around the world. But another possibility is that they have disrupted cortisol rhythms. So we don't exactly know what it is, but there's growing evidence that disruption of circadian cycles may put people at risk for getting cancers and for the more rapid progression of them.

Q: Does meditation help lower cortisol levels?

A: That may be the case. I think there have been a couple of studies that suggest that meditation may help to lower cortisol levels. There's one terrific study that Jon Kabat-Zinn did with psoriasis patients. These are patients who have this sort of flaky, cracked skin, and they get treatments with a drug called psoralens and also ultraviolet light that seems to help. So they have to lie there under this light for a long time. In the study, patients either got music or they got training in mindfulness-based stress reduction. The ones who got the mindfulness training actually healed up quicker than the ones who had the music. That may be mediated by cortisol; it may be some other way. So it wouldn't surprise me. Studies are now emerging that show that these kinds of techniques that alter mental stress may also alter the stress response system.